Acuitus Medical Ltd

Quality Report

The Business Centre
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

Acuitus Medical Ltd is operated by Acuitus Medical Ltd. The service provides day case cosmetic surgery. Facilities include one operating theatre, an admissions room, a recovery room, one consultation room and a decontamination room. There is also a waiting room and toilet and shower.

We inspected this service to follow up on three requirement notices issued following our comprehensive inspection in May 2017. The requirement notices were issued for breaches of regulation 12 (safe care and treatment), regulation 17 (good governance) and regulation 19 (fit and proper persons employed). We carried out an unannounced inspection on 18 December 2017.

We regulate cosmetic surgery services but we do not currently have a legal duty to **rate** them when they are provided as a single specialty service. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- All medicines and medicine keys were stored securely.
- The operating room was fully commissioned and compliant with HTM 03-01.
- Staffing levels and responsibilities were compliant with the Academy of Medical Royal Colleges Safe Sedation Practice for Healthcare Procedures 2013 when sedating patients.

However, we also found the following issues that the service provider needs to improve:

- The decontamination room had not been commissioned in line with Health Technical Memorandum (HTM) 01-01 Part A.
- Not all patients were risk assessed for venous thromboembolism (VTE) on admission. This was identified at the previous inspection and was still a concern.
- Not all patients had all the necessary observations completed before, during or after their surgery. This was identified at the previous inspection and was still a concern.
- Not all patients had the World Health Organisation's (WHO) 'Five Steps to Safer Surgery' checklist completed. This was identified at the previous inspection and was still a concern.
- Not all staff had evidence of completing their mandatory training. This was identified at the previous inspection and was still a concern.
- Not all patients with a history of mental health concerns received a psychological assessment prior to proceeding with their cosmetic surgery. This was identified at the previous inspection and was still a concern.
- In the operating room, we found two endotracheal tubes on the resuscitation, which went out of date in June 2017. We found other pieces of equipment out of date at our previous inspection.
- Medications for patients to take home after surgery were not labelled in accordance with the Human Medicines Regulations Schedule 26.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with two warning notices and one requirement notice. Details are at the end of the report.

Heidi Smoult

Deputy Chief Inspector of Hospitals (Central)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery		• The decontamination room had not been commissioned in line with Health Technical Memorandum (HTM) 01-01 Part A. • Not all patients were risk assessed for venous thromboembolism (VTE) on admission. This was identified at the previous inspection and was still a concern. • Not all patients had all the necessary observations such as blood pressure and pulse completed before, during or after their surgery. This was identified at the previous inspection and was still a concern. • Not all patients had the World Health Organisation' (WHO) 'Five Steps to Safer Surgery' checklists completed. This was identified at the previous inspection and was still a concern. • Not all staff had evidence of completing their mandatory training. • Not all patients with a history of mental health concerns received a psychological assessment prior to proceeding with their cosmetic surgery. This was identified at the previous inspection and was still a concern. • We found two endotracheal tubes on the resuscitation trolley within the operating room, which went out of date in June 2017. We found other pieces of equipment out of date at the previous inspection. • Medications for patients to take home after surgery were not labelled in accordance with the Human Medicines Regulations Schedule 26. However • All medicines and medicines keys were stored securely. • The operating room was fully commissioned and compliant with HTM 03-01. • Staffing levels and responsibilities were compliant with the Academy of Medical Royal Colleges Safe Sedation Practice for Healthcare Procedures 2013 when sedating patients.

Summary of findings

Contents

Location name here

Services we looked at

Surgery;

Summary of this inspection

Background to Acuitus Medical Ltd

Acuitus Medical Ltd is operated by Acuitus Medical Ltd. The service opened in 2015. It is a private cosmetic clinic in Watford, Hertfordshire. The hospital primarily serves the communities of London and the Home Counties. It also accepts patient referrals from outside this area. Services are provided for patients aged over 18. It provides a range of cosmetic procedures including rhinoplasty (nose reconstruction), rhytidectomy (facelift), breast augmentation (implants), breast reduction, liposuction (fat removal) and abdominoplasty (tummy tuck). All patients are seen on a day case basis.

The hospital has had a registered manager in post since 11 June 2015. The unannounced focused inspection occurred on 18 December 2017.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, a CQC inspection manager and a second CQC inspector. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

Information about Acuitus Medical Ltd

The hospital has one day case theatre and is registered to provide the following regulated activities:

- Surgical procedures
- Treatment of disease, disorder and injury

During the inspection, we visited the day case theatre, the consultation room, the admissions room, the recovery room and the decontamination room. We spoke with seven staff including; the registered manager, a registered nurse, a surgeon, an anaesthetist and three administrators. During our inspection, we reviewed 15 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The service had been inspected once in May 2017, which found that the service was not meeting all the standards of quality and safety it was inspected against. This led to three requirement notices being issued; for regulation 12 (safe care and treatment), regulation 17 (good governance) and regulation 19 (fit and proper persons employed).

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Interpreting services
- Maintenance of medical equipment

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Are services safe?

We do not currently have a legal duty to rate cosmetic surgery services.

We found the following issues that the service needs to improve:

- The decontamination room had not been commissioned in line with Health Technical Memorandum (HTM) 01-01 Part A.
- Not all patients were risk assessed for venous thromboembolism (VTE) on admission. This was identified at the previous inspection and was still a concern.
- Not all patients had all the necessary observations such as blood pressure and pulse completed before, during or after their surgery. This was identified at the previous inspection and was still a concern.
- The World Health Organisation's (WHO) 'Five Steps to Safer Surgery' checklists were not completed for all patients all of the time. This was identified at the previous inspection and was still a concern.
- Not all staff had evidence of completing their mandatory training.
- Not all patients with a history of mental health concerns received a psychological assessment prior to proceeding with their cosmetic surgery. This was identified at the previous inspection and was still a concern.
- Within the operating room, we found two endotracheal tubes on the resuscitation trolley, which went out of date in June 2017. We found other pieces of equipment out of date at the previous inspection.
- Medications for patients to take home after surgery were not labelled in accordance with the guidance.

However, we found the following areas of good practice:

- All medicines and medicines keys were stored securely.
- The operating room was fully commissioned and compliant with HTM 03-01.
- Staffing levels and responsibilities were compliant with the Academy of Medical Royal Colleges Safe Sedation Practice for Healthcare Procedures 2013 when sedating patients.

Are services effective?

Are services effective?

Summary of this inspection

We do not currently have a legal duty to rate cosmetic surgery services.

We found the following issues that the service needs to improve:

- New staff did not all have a documented induction. This was identified at the previous inspection and was still a concern.

However, we found the following area of good practice:

- Most patients observed the two week cooling off period between consultation and the procedure being performed. Where this did not happen, we saw signed disclaimers in patients' records.

Are services caring?

Are services caring?

We did not review this as part of our inspection.

Are services responsive?

Are services responsive?

We did not review this as part of our inspection.

Are services well-led?

Start here..

Are services well-led?

We do not currently have a legal duty to rate cosmetic surgery services.

We found the following issues that the service needs to improve:

- Although patient safety audits, including audits of VTE and WHO checklists had been introduced, these were not comprehensive and did not provide assurances that these patient safety checklists were being completed.
- Staff meetings were not formalised or minuted. As such, staff did not receive minutes or summaries from team meetings. This was identified at the previous inspection and was still a concern.

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Detailed findings from this inspection

Mental Health Act responsibilities

Start here...

Mental Capacity Act and Deprivation of Liberty Safeguards

Start here...

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Notes

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are surgery services safe?

Incidents

- During our last inspection we found that patients who had their surgery within the two week cooling off period were not recorded as incidents. On this inspection, we found that these patients were still not recorded as incidents. However, the process for managing these patients and their ability to consent to treatment had improved. More information on this can be found in the section of the report titled 'Consent, Mental Capacity Act and Deprivation of Liberty Safeguards'.

Clinical Quality Dashboard or equivalent

- The registered manager told us that all patients were risk assessed for venous thromboembolisms (VTE) on admission. VTEs are blood clots that can form in a vein and have the potential to cause severe harm to patients. At our last inspection, we raised concerns that two out of six patient records reviewed did not have evidence of VTE assessment. On this inspection, we reviewed 15 patient records and we found that 10 out of 15 assessments were not completed and one was half completed. Therefore we were not assured that VTE risk assessment were being carried out on all patients.
- VTE audits were completed monthly on five sets of notes which were chosen at random. This had been introduced following our previous inspection in May 2017. During our inspection in December 2017, we reviewed three sets of audits from September, October and November 2017. The audits lacked detail and did not provide assurances that VTE assessments were being completed correctly or that the audit would lead to improvement in practices. The audit template gathered limited information and did not provide details of the patients who were audited or the staff involved in their care. Therefore, there was limited opportunity for identifying themes and improving practice.
- The September and October 2017 audit results showed that there was partial compliance with the VTE risk assessment. This did not show whether one out of five patients had received an assessment, or whether four out of five patients had received one. As such, there was limited learning or insight available. There were no action plans resulting from these audits. The registered manager had written at the bottom of the form that the results were to be discussed at the Medical Advisory Committee. However, we found this did not always occur. Further details on this can be found in the well-led section of this report.

Cleanliness, infection control and hygiene

- Clean and dirty surgical equipment was stored in the decontamination room. Instruments were cleaned, inspected, packed and autoclaved in the decontamination room by clinical staff. However, the decontamination room had not been commissioned in line with national safety guidance Health Technical Memorandum (HTM) 01-01 part A. This meant that there was no evidence that the decontamination room was being used in accordance with national safety guidance or was compliant with guidance. This was not listed on the risk register, despite the registered manager telling us that it was. We raised this with the registered manager who told us that the service was following national dental guidance on decontamination HTM 01-05 Decontamination in primary care dental practices. However, this was not appropriate as the procedures being undertaken were not dental but cosmetic surgery. We raised this with the registered manager at the time of our inspection who stopped using the decontamination room and this process for decontaminating equipment.

The registered manager confirmed that single use equipment would be used as well as outsourcing decontamination to another service until the decontamination room and process was compliant with HTM 01-01 part A.

- There were no expiry dates on the instrument packs. Therefore, we could not be assured that these items would be used within a safe timeframe in line with HTM 01-01.
- Decontaminated instruments were not tracked and traced in line with HTM 01-01. This is necessary to ensure that the service knows which instruments were used for which patients. There were no audits undertaken regarding the tracking and tracing of instruments. We were told this would start in January 2018.
- We also saw that eye protection was not worn by staff during the decontamination process.
- We were told that the decontamination room had negative pressure airflow. Negative room pressure is an isolation technique used to prevent cross-contamination from room to room. However, the service did not have a certificate to evidence this so we could not be assured that national safety guidance was being adhered to.
- The storage area for intravenous fluids (IV), sterile instruments and consumables was disorganised and untidy with open boxes stored on the floor. This potentially posed a trip or fire hazard and potentially equipment could bet wet during cleaning or due to a flood.
- The temperature in the storage area was not checked. This meant that variations in temperature that may affect the safe keeping of IV fluids was not monitored so that fluids could be discarded in the event of the temperature being too high or low.
- The patient consultation room contained a wash hand basin. This was in line with Department of Health Guidelines 2013 HBN009 which states that clinical handwashing basins should be available for clinical staff to wash their hands in between patients. This was an improvement from the last inspection in May 2017.
- At our previous inspection in May 2017, we raised concerns that theatre clothing (scrubs) were being washed by staff at home. Following us raising these concerns, the service introduced single use theatre scrubs. On this inspection, we saw that reusable scrubs had been reintroduced. However, the administrative staff now washed and ironed these in-house. We saw that scrubs were washed at 90 degrees Celsius. This was higher than the minimum requirement of 60 degrees Celsius, which was noted in the service's uniform policy. Single use scrubs were also available.

Environment and equipment

- During our previous inspection, we found the operating room had not been commissioned in line with HTM 03-01. As such, we were not assured of the safety of the operating room. On this inspection, we saw evidence that there was a newly built operating room that had been appropriately commissioned.
- When the clinic was open, staff completed checks of the resuscitation trolley. A checklist was in place and the trolley followed an organised format, in accordance with the Resuscitation Council UK guidelines. This was an improvement from the last inspection. However, we found two endotracheal tubes (tubes that are inserted into the windpipe in the event of a patient requiring artificial ventilation) which were six months out of date. We escalated this as a concern and the registered manager removed these from use immediately.
- There was a separate storage rack to provide rapid access to face masks, ventilation adaptors (attached to the anaesthetic machine) and nasal cannulas (tubes which are inserted into a patient's nose to support their airway). These had not been restocked, and there were no nasal cannulas available and a limited supply of ventilation adaptors.
- The ventilation equipment for the operating room was installed in the patient recovery area. The keypad buttons were uncovered and unsecured therefore, this posed a risk that the airflow could be accidentally adjusted if a patient or member of staff accidentally leant on the keypad. This was on the service's risk register which indicated plans were in place to appoint a carpenter to create a cover to prevent the keypad buttons being accidently adjusted. However we did not see a date for when this would be completed by.
- A major haemorrhage pack was in place in accordance with National Patient Safety Agency 2007 Rapid Response. This was colour coded and a checklist was available. This was an improvement from the previous inspection, when there was no pack in place. The

checklist was only available electronically and the registered manager sent us the latest checklist, dated 13 December 2017. This indicated all stock was present and within its expiry dates.
- We saw that sharps bins were labelled with dates of assembly and closure in accordance with s.5 of the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. This was an improvement from our last inspection in May 2017, where we found sharps bins without dates of issue.

Medicines

- All drugs and medicines were in date at the time of inspection. This was an improvement from our last inspection, when we found medicines out of date.
- Medications, including controlled drugs, were stored in locked cupboards, in accordance with the Royal Pharmaceutical Council Great Britain guidelines. All of the keys were secured in keypad locked wall mounted storage boxes. This was compliant with Department of Health guidance, which states that controlled drugs keys need to be kept securely inside a locked key cupboard. This was an improvement from our previous inspection, where keys were not stored securely.
- At our previous inspection in May 2107, we raised concerns about the signing for controlled drugs, as only one clinician was signing the controlled drugs book. The drawing up and administering of controlled drugs needs to be overseen by two clinicians, with both clinicians signing the controlled drugs book, in accordance with National Institute for Health and Care Excellence (NICE) guideline NG46. This is because additional checks that are required, due to the potential for controlled drugs to be misused. At this inspection, we saw that two clinicians signed for the administration of any controlled drugs.
- Medications for patients to take home after surgery were not labelled appropriately. Whilst the medication information was provided in a summary sheet, there was no dosage labelling of the individual medication boxes. This was not in line with the Human Medicines Regulations Schedule 26 packaging requirements: special provisions. This states that the label should contain the name of the product or its common name; directions for use of the product; and precautions relating to the use of the product.

Records

- Patients' individual care records were not always completed and up to date. We reviewed 15 patient records. We found that not all VTE assessments were completed with 10 out of 15 being incomplete. We also found that not all patients' records had World Health Organisation (WHO) 'Five Steps to Safer Surgery' checklists completed. We found eight out of 15 records incomplete and 10 out of 15 records did not have National Early Warning Score (NEWS) charts completed. NEWS is a tool developed by the Royal College of Physicians, which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes.

Safeguarding

- This was not reviewed as part of this inspection.

Mandatory training

- Not all staff had evidence that they had completed their mandatory training. The clinic employed 14 members of staff. Of these, eight staff members had evidence of mandatory training. We raised concerns about the lack of mandatory training at our last inspection, and found that issues still remained on this inspection.

Assessing and responding to patient risk

- The service had implemented a nationally recognised NEWS (National Early Warning System) tool, to identify a deteriorating patient. This was in line with NICE guidance CG50. However, we found omissions in the completion of the NEWS charts, as noted above in the 'records' section of this report. Therefore, we were not assured that patients' observations had been recorded and that a potential deteriorating patient would be recognised.
- We found omissions of VTE assessments and the WHO "Five Steps to Safer Surgery" checklists as these were not completed for all patients. These checklists ensure that risk assessments are undertaken for patients. Therefore, we were not assured that staff were assessing patients' risks.
- Completion of the WHO checklist was audited monthly, on a combined audit with VTE assessments. We saw the last three sets of audits; September, October and November 2017. The audits lacked detail and did not provide assurances that WHO checklists were being conducted or that the audit mechanism would lead to

improvement. The audit template was limited, did not provide details of the patients who were audited or the staff involved in their care. Therefore, there was limited opportunity for identifying themes or improvement in practice.

- The September and November 2017 audits stated that there was partial compliance with the WHO checklist. However, similar to the VTE audit, this did not show how many patients had been missed. As such, there was limited learning or insight available. There were no formalised action plans resulting from these audits. The registered manager had written that the results were to be discussed at the Medical Advisory Committee. However, we found this did not always occur. Further details on this can be found in the well-led section of this report.
- Not all patients had observations recorded before, during or after surgery. From the 15 records we reviewed, two patients had no evidence of any observations at all and five patients did not have evidence of any baseline observations. This meant staff were unable to tell if their vital signs were within normal ranges prior to going into theatre and if they had returned to a normal level before discharging them. This concern was also identified at the previous inspection, and was still happening.
- At our previous inspection we raised concerns that there was a patient who was taking antidepressants who had two cosmetic procedures performed without evidence of a GP summary or psychological risk assessment. At this inspection, we saw that the service operated on another patient who was suffering from depression and taking antidepressants. There was also no evidence of a GP summary or a psychological risk assessment for this patient. Therefore, this was still a concern at this inspection.

Nursing and support staffing

- Since the previous inspection, a registered nurse had been employed. At the time of our inspection in December 2017, the registered nurse was undergoing an induction programme. However, there was no formal documented evidence available to identify progress.
- The nurse worked in all areas of the service including outpatients, pre-assessment, theatre and recovery. The nurse was having internal training to ensure they were competent in all these areas. However, we did not see any evidence of competencies.

Medical staffing

- At our last inspection we raised concerns about staffing levels in the operating room when patients were being sedated. On this inspection, we saw that staffing levels and responsibilities were now compliant with the Academy of Medical Royal Colleges Safe Sedation Practice for Healthcare Procedures 2013.

Emergency awareness and training

- This was not reviewed as part of this inspection.

Are surgery services effective?

Evidence-based care and treatment

- This was not reviewed as part of this inspection.

Pain relief

- This was not reviewed as part of this inspection.

Nutrition and hydration

- This was not reviewed as part of this inspection.

Patient outcomes

- The service had started collecting Q-PROMS (patient reported outcome measures) for liposuction, abdominoplasty and breast procedures since our previous inspection. However, due to the limited number of patients operated on, there was insufficient data numbers to identify any themes.
- The service had registered with the Private Healthcare Information Network (PHIN), which became a legal requirement in September 2016. We saw evidence that they had paid their subscription fee.

Competent staff

- On our inspection we found, not all new staff had documented inductions. We spoke with three new staff members; one registered nurse and two administrators. None of these staff members were aware of an induction document or competency checklist. We raised this as a concern with the registered manager, who then sent us a copy of a checklist for the registered nurse. This contained a list of training they needed to undertake, but was not updated with evidence of progress. We raised similar concerns during our last inspection, regarding the induction process. Therefore, this was still a concern at this inspection.

Surgery

- At our last inspection in May 2017, we found that one staff member out of seven employment files reviewed had evidence of two written employment references. On this inspection, we found that 14 staff members were employed, but only eight of these had two references on file. One staff member had one reference on file, and we were not provided with any evidence for the remaining staff members. Therefore this was still a concern at this inspection.

Multidisciplinary working

- This was not reviewed as part of this inspection.

Access to information

- This was not reviewed as part of this inspection.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- At our last inspection, we found that the service was not applying the two week cooling off period as required by the RCS Professional Standards for Cosmetic Surgery. This was to allow patients time to ensure they wanted to go ahead with the procedure. We were told that if this happened, patients signed an additional disclaimer. However, we did not see evidence of this in any patient notes.
- On this inspection, we saw that disclaimers were signed in cases when surgery had taken place within two weeks of the initial consultation.

Are surgery services caring?

Compassionate care

- This was not reviewed as part of this inspection.

Understanding and involvement of patients and those close to them

- This was not reviewed as part of this inspection.

Emotional support

- This was not reviewed as part of this inspection.

Are surgery services responsive?

Service planning and delivery to meet the needs of local people

- This was not reviewed as part of this inspection.

Access and flow

- This was not reviewed as part of this inspection.

Meeting people's individual needs

- This was not reviewed as part of this inspection.

Learning from complaints and concerns

- This was not reviewed as part of this inspection.

Are surgery services well-led?

Vision and strategy for this core service

- This was not reviewed as part of this inspection.

Governance, risk management and quality measurement

- At our last inspection, we raised concerns that not all patient safety audits were being completed. This included audits on completion of venous thromboembolism (VTE) assessments and Q-PROMS (patient reported outcome measures). On this inspection, we saw that audits had been completed in these areas. However, the combined audit which covered VTE and the World Health Organisation (WHO) 'Five Steps to Safer Surgery' checklist completion was limited and did not adequately identify any themes or learning. In addition, the audits said that areas of concern would be raised at the next Medical Advisory Committee (MAC) meeting. From review of the MAC minutes, we saw that two sets of audits had been completed (October and November 2017) in advance of the November MAC meeting. Both audits had identified failings but neither was discussed at the November MAC meeting.
- We saw that the service had improved its operating room ventilation systems, the management of medications, the management of major haemorrhage packs and resuscitation trolleys, the management of sharps bins and the cleaning of theatre uniforms. We had raised previous concerns about these areas during our last inspection in May 2017. Information on how these were now being managed can be found in the 'safe' section of this report.

Leadership / culture of service related to this core service

Surgery

- This was not reviewed as part of this inspection.

Public and staff engagement (local and service level if this is the main core service)

- This was not reviewed as part of this inspection.

Innovation, improvement and sustainability

- This was not reviewed as part of this inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all patients are risk assessed for venous thromboembolism.
- The provider must ensure that all observations, including National Early Warning Scores, are undertaken and recorded in patient records.
- The provider must ensure that all World Health Organisation 'Five Steps to Safer Surgery' checklists are always completed.
- The provider must ensure that thorough patient safety audits are completed, including venous thromboembolism and World Health Organisation 'Five Steps to Safer Surgery', and outcomes are shared with staff. Where areas for improvement are identified, action plans must be completed and followed through.
- The provider must ensure surgical instrument are processed and stored in line with national guidance.
- The provider must ensure that all staff have evidence of mandatory training, including safeguarding training, and evidence of employment references.
- The provider must ensure that staff receive minutes or summaries from team meetings.
- The provider must ensure that all new staff have evidence of an induction.

Action the provider SHOULD take to improve

- The provider should ensure that all staff wear adequate eye protection during the decontamination of instruments.
- The provider should ensure that all storage areas are tidy and do not pose a slip or fire hazard.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (2)(a)(d)(e)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance How the regulation was not being met: Team meetings were not formalised or minuted. New staff did not have evidence of an induction programmes or completion of competencies. Staff files were not up to date with information including mandatory training and references. Surgical instruments were not being processed in line with national guidance. Compliance with venous thromboembolism assessments and World Health Organisation's 'Five Steps to Safer Surgery' checklists had started to be assessed though audits. However there was limited learning and actions taken.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(1), Safe care and treatment **12.**—(1) Care and treatment must be provided in a safe way for service users. assessing the risks to the health and safety of service users of receiving the care or treatment; doing all that is reasonably practicable to mitigate any such risks; (e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way; We have served the hospital a warning notice for a breach of this regulation. How the regulation was not being met: Systems to assess, monitor and mitigate risks to patients receiving care and treatment are not operating effectively. Out of a total of 15 patient records, we found that 11 of these patient records had blank or incomplete venous thromboembolism (VTE) risk assessments. The risk of patient harm as a result of not carrying out VTE assessments was not being managed. World Health Organisation 'Five Steps to Safer Surgery' checklists were not being completed. The risk of a patient suffering harm as a result of surgical safety checks not being completed was not being managed. We found seven patients had evidence of incomplete observations. Two patients had no evidence of any

This section is primarily information for the provider

Enforcement actions

observations and five patients had no evidence of baseline observations. The risk of a patient suffering harm as a result of their clinical deterioration not being identified was not being managed.

We found evidence of one patient who had disclosed a history of depression and was on an antidepressant medication. There was no evidence that they had undergone a psychological assessment or that a GP summary had been sought. The risk of a patient undergoing treatment when they were not in an appropriate mental or emotional state was not being managed.

We found two endotracheal tubes which were six months out of date. The risk of a patient suffering harm as a result of out of date equipment was not being managed.